

SUMMARY OF BENEFITS

Delta Dental Plan of Arizona, Inc. Employer Group Dental Contract

Group : 7777

Group Name : STATE OF ARIZONA

Summary

Effective Date : 10/01/2003

This is the date which this document is effective.

Contract Year : October 1st through September 30th

This is the twelve (12) month period for which these Contract benefits apply

Benefit Year : October 1st through September 30th

Benefit Year means the annual period specified in the Employer Group Dental Contract for calculation of benefits, co-payment, and deductibles under This Contract.

Age Limits : Child: 19 Student: 25

Deductible : \$50.00 per person, \$150.00 per family

Annual Benefit Year Maximum : \$2000.00

REFER TO THE DENTAL BENEFITS BOOKLET DESCRIPTION OF SERVICES FOR A MORE DETAILED DESCRIPTION INCLUDING LIMITATIONS AND EXCLUSIONS. BENEFITS SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE EMPLOYER GROUP DENTAL CONTRACT.

Predetermination recommended for services over \$250.

Routine

(Deductible does not apply to these services)
(No waiting period)

100%

Diagnostic

- Exams of any type, including consultations (Twice in a Benefit Year)
- X-rays: Full Mouth/Panorex (Once in a three (3) year period) Bitewing (Twice in a Benefit Year) Periapical- As needed

Preventive

- Routine Cleanings (limited to twice in a benefit year, or one (1) difficult cleaning may be exchanged for two (2) routine cleanings) However, the difficult cleaning is limited to not more than once in a two (2) year period.
- Topical Application of Fluoride (children to the age of eighteen (18) - twice in a benefit year)
- Space Maintainers (For missing posterior primary teeth) up to age fourteen (14)

Basic

(Deductible does apply to these services)
(No waiting period)

80%

Restorative

- Fillings consisting of silver amalgam; or composite tooth color fillings.
- Sealants for children (Once in a three (3) year period for permanent molars & bicuspid through age eighteen (18).
- Stainless Steel Crowns (For primary teeth only)

Oral Surgery

- Extractions and Surgical Procedures including pre and post treatment care

Periodontics

- Treatment of Gum Disease (Non-surgical-once every two (2) years/Surgical once every three (3) years).

Endodontics

- Endodontic surgery Limited to once in a three (3) year period.
- Root Canal Treatment (Permanent Teeth);Pulpotomy (Primary Teeth) Once per tooth per lifetime.

Emergency (Palliative Treatment)

- Emergency treatment for the relief of pain

Major

(Deductible does apply to these services)
(No waiting period)

50%

Restorative

- Cast Crowns - Onlays (five (5) year waiting period for replacement last benefited by any carrier)

Prosthodontics

- Bridges -Does not provide for lost, misplaced or stolen bridges or dentures. Five(5) year waiting period for replacement last benefited by any carrier.
- Complete Dentures - Does not provide for lost, misplaced or stolen bridges or dentures. Five(5) year waiting period for replacement last benefited by any carrier.
- Partial Dentures - Does not provide for lost, misplaced or stolen bridges or dentures. Five(5) year waiting period for replacement last benefited by any carrier.

Bridge and Denture Repair

- Repair of such appliances to their original condition including relining of dentures.

Orthodontic Services

- **ORTHODONTICS:** The program will pay (50%) of the Orthodontics Services for an eligible employee, eligible spouse or eligible dependent child age eight (8) or older limited to payment of monthly or other periodic charges through completion of treatment or to the date eligibility terminates, whichever occurs first. Benefits are limited to a maximum of (\$1,500) per lifetime of the patient. This maximum is separate from the benefit year maximum for your other dental benefits.

The Plan will give any Dentist, Eligible Person or Member, on request, a standard claim form to make a claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who completed the services and by the Eligible Person (or the parent or guardian if the patient is a minor) and submitted to the Plan. If the form is not furnished to the Plan within 15 days after requested by a Dentist or an Eligible Person, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to the Plan, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss which claim is made.

Affirmative proof of loss must be furnished to the Plan at its office within 90 days after termination of care for which Benefits are payable hereunder. Failure to furnish proof of losses within that time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss within such time and that such proof of loss was furnished as soon as was reasonably possible.

Benefits payable under this Contract for any loss other than loss for which this Contract provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Contract provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. All or a portion of any benefits provided by the Contract may, at the Plan's option, be paid directly to the Dentist providing such services, but it is not required that the service be provided by a specific Dentist. All Benefits not paid directly to the Dentist shall be payable to the Eligible Person, or to his/her estate, except that if the Eligible Person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

No action at law or inequity shall be brought to recover on the Contract prior to the expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor shall an action be brought at all unless brought within three years from expiration of the time within which proof of loss is required by the Contract.

**Delta Dental Plan of Arizona
P.O. Box 43000
Phoenix, Arizona 85080-3000**

Delta Dental Plan of Arizona is responsible for determining benefits as described in this booklet, and for authorizing payment of administrative expenses incidental thereto.

DELTA DENTAL PLAN OF ARIZONA NOTICE OF PRIVACY AND INFORMATION PRACTICES

THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

At Delta Dental Plan of Arizona (Delta), we use health information and personal information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. We NEVER sell any information we collect while processing transactions on your request while you are covered under Delta or after your coverage ends.

Delta collects information about you (examples include full-time student status, handicap status, guardianship status documents) through the enrollment process and through the payment of claims. This information collection, use, and disclosure is how Delta's customer service representatives, claims processors, and other staff properly administer group dental contracts as well as communicate to dental offices. Delta is permitted to use or disclose protected health information to the individual, pursuant to an authorization, and for treatment, payment, or health care operations. We may use and disclose your protected health information in these instances.

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Delta may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for

Delta Dental Plan of Arizona will directly, or in consultation with a review committee of the pertinent local or state dental society, investigate the circumstances and appropriate disposition of the complaint.

Claims Appeal

DDPAZ will notify the eligible member if benefits are denied for any services and why. A separate Health Care Insurer Appeals Process Information Packet is available on our web site (www.deltadentalaz.com) or by request, which describes the appeal process a member may pursue. For a copy of this packet, go to our website or contact the Customer Service Department at (800) 352-6132, ext. 2 (outside metro Phoenix). Phoenix area calls should be made to (602) 938-3131, ext. 2. Or, write to:

**Customer Service Department
Delta Dental Plan of Arizona
P.O. Box 43000
Phoenix, Arizona 85080-3000**

Claims Inquiry

A toll-free number is available for your use in calling Delta Dental to inquire about claims, claim payment status or a specific Dentist's membership status. This number is (800) 352-6132. Phoenix area calls should be made to (602) 938-3131.

Cancellation of Program

Delta Dental may cancel the program only:

1. On an anniversary of the effective date; or
2. If your employer does not pay the monthly premiums; or
3. If your employer does not provide a list of eligible members.

Delta Dental is not required to pay benefits for services provided after the cancellation date.

Delta Dental shall not pay for any claim submitted more than six months after the date of termination of the Group Contract or Policy. Written notification will be made to the member and group policyholder.

Provisions Required By Law

Before approving a claim, the Plan will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to, or examination of, or treatment provided to, an Eligible Person as may be required to administer the claim, or that an Eligible Person be examined by a dental consultant retained by the Plan, in or near his/her community or residence. The Plan shall in every case hold such information and records confidential.

Multiple Coverage

If a person is eligible for benefits under two or more programs underwritten by Delta Dental, and more than one of the programs provides coverage for an allowable benefit, Delta Dental will pay according to this provision.

Right of Recovery

Delta Dental shall recover any payment made that is more than the obligation determined by the rules of the Coordination of Benefits provision.

How does Delta Dental determine which is the “primary” program?

1. The program covering the patient as a member is primary over a program covering the patient as a dependent.
2. When the patient is a dependent child, then the birthdays of the parents determine which program is primary. The program of the parent whose birthday (month and day, not year) occurs earlier in a calendar year is primary and will pay its benefits first. The program covering the parent whose birthday occurs later in the year is secondary.
3. When the parents of a dependent child are legally separated or divorced, the program covering the parent with legal custody is primary. The program covering the spouse of the parent with custody (i.e., stepparent) is next. The program of the parent not having legal custody is last. However, if there is a court decree assigning the responsibility for healthcare expenses of the child to one parent, then the program covering that parent is primary.
4. If the patient is a member of a pre-paid dental plan (managed care program) and is also insured under an indemnity plan (Delta Dental), then the indemnity plan is primary, without regard to the existence of the pre-paid dental plan.
5. If the above rules do not apply, or if there are two “primary” coverage plans due to retirement, then the program covering the patient longer is primary.

Complaints Concerning Quality Of Dental Care

This dental program recognizes the right of each member or dependent to select a Dentist of his or her own choosing. Neither your employer nor Delta Dental Plan of Arizona assumes any responsibility for the selection of Dentists or for the quality of dental care by such Dentists.

However, all these parties are vitally interested in resolving questions that may arise concerning availability or quality of dental care. In fact, Delta Dental Plan of Arizona is committed to assuring to the degree possible that the professional services provided under this program do meet professionally established standards of dental health care. Members who have questions concerning the quality of treatment received, either personally or by their dependents, should direct those questions to:

**Professional Services Department
Delta Dental Plan of Arizona
P.O. Box 43000
Phoenix, Arizona 85080-3000**

your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. You may opt out of this provision by sending us a written statement.

Delta, as a health insurance issuer, with respect to a group health plan, may disclose protected health information to the sponsor of the plan.

We will share your protected health information with third party “business associates” that perform various activities (e.g., printing of checks and explanations of benefit [EOBs]) for Delta. Whenever an arrangement between Delta and a business associate involves the use or disclosure of your protected health information, we will have a written contract with the business associate that contains terms to protect the privacy of your protected health information.

Authorizations

We provide information without obtaining your authorization, when required by law (such as for law enforcement in specific circumstances), when requested by the Arizona Department of Insurance or when required by the Secretary of Health and Human Services. Other examples include, public health and health oversight activities, judicial and administrative proceedings, coroners and medical examiners, Governmental health data systems, directory information, banking and payment processes, research purposes, emergency circumstances, next-of-kin, specialized classes (military purposes, Dept. of Veterans Affairs, the intelligence community, Dept. of State), and other requirements defined by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

In situations other than routine administration or as described above, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. This request can be made at any time, in writing, except to the extent that Delta has taken an action in reliance on the use or disclosure indicated in the authorization.

You can be assured that when processing or servicing a transaction at your request, only the minimum necessary information regarding your account or personal history information will be used or disclosed, as permitted by law. Delta applies the “most stringent” law to your health information. That means that you are afforded the most protection whether that is from Federal or State Regulation. Greater individual rights of access and amendment provides greater privacy protection for the individual who is the subject of the individually identifiable health information.

When You Get A Notice

This notice must be provided no later than the compliance date to individuals then covered by the plan and within 60 days of a material revision to the notice, to individuals then covered by the plan. No less frequently than once every three years, the health plan must notify individuals then covered by the plan of the availability of the notice and how to obtain the notice. The health plan may provide the notice to the named insured of a policy under which coverage is provided to the named insured and one or more dependents. If you requested or agreed to receive this notice electronically, you may obtain a paper copy upon request.

We may change our policies at any time. However, before we make a material revision to our policies, we will change our notice of information practices and deliver the revised notice as required by law. The revised notice will be effective for all protected health information that we maintain at that time. Except when required by law, a material change to any term of the notice may not be implemented prior to the effective date of the notice in which such material change is reflected. You can also request a copy of our notice at any time by accessing our website at www.deltadentalaz.com or by calling the office and requesting that a revised copy be sent to you in the mail. For more information about our privacy practices, please contact the person listed below.

Individual Rights

In most cases, you have the right to request and to receive a copy of health information about you that we use to make decisions about you. If you request copies, you will be charged \$0.10 (10 cents) for each page. You also have the right to request and to receive a list of instances where we have disclosed health information about you. Delta does not routinely record the identity of the recipient of the information that we have disclosed to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract, to perform quality assurance, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

You may request in writing to receive communications of protected health information from Delta by alternative means or at alternative locations. You must clearly say in the statement that disclosure of all or part of the information to which the request pertains could endanger you. We must accommodate reasonable requests that can be conditioned upon the specification of an alternative address or other method of contact.

Complaints

10. Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: altering vertical dimension, replacing or stabilizing tooth structure lost by attrition wear or bruxism, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration, bite appliances or harmful habit appliances.
11. Plaque control, oral hygiene instruction, allergic reaction treatments, study models, casts and other ancillary services not covered in this Contract.
12. Implants, materials implanted or grafted into or onto bone or soft tissue, or removal of implants, except when covered by this Contract.
13. Travel time and related expenses.
14. Direct diagnostic or surgical and non-surgical treatment procedures applied to body joints or muscles, temporal mandibular joint (TMJ) or temporal mandibular disturbances (TMD) are not covered.
15. All other services not specified as covered dental services.
16. Delta Dental shall not pay claims received in Delta's office more than one-year after the date of service.
17. Experimental or transitional procedures, or any procedure other than those covered services for which the prognosis is good. Any procedure done in anticipation of future need (except covered preventive services).
18. Myofunctional therapy or speech therapy.
19. Services not performed in accordance with the laws of the State of Arizona, services performed by any person other than a person authorized by license to perform such services, or services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition as explained herewith.
20. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
21. Replacement of lost, stolen or damaged dental appliances.
22. Preparation for placement or replacement, removal or repair or any other procedure related in any way to any procedure or services not included in Covered Services.
23. Services performed and completed by anyone other than a licensed Dentist.

Coordination of Benefits

Delta Dental coordinates the benefits under this program with you or your dependent's benefits under any other group managed care program or insurance policy. Benefits under one of these programs may be reduced so that your combined coverage does not exceed the allowable fees for the covered service. If this plan is the "primary" program, Delta Dental will not reduce benefits, but if the other program is primary, Delta Dental will reduce benefits. The reduction will be the amount paid under the terms of the primary program. (See Covered Dental Service.)

Right to Receive and Release Necessary Information

Delta Dental may release or obtain information from any insurance company or other person(s) as necessary to meet the Coordination of Benefits provisions of this Contract. Delta Dental shall determine the existence of, or amount payable under any other program, through the eligible person claiming benefits under this Contract.

service rather than a separate service, and separate payment shall not be made for a temporary service unless otherwise included as a covered service of this Contract.

5. In the event that an eligible person transfers from the care of one Dentist to that of another Dentist during a course of treatment, or if more than one Dentist renders services for the same dental procedure, Delta Dental shall not be liable for more than the amount it would have been liable had but one Dentist rendered all the services during each course of treatment, nor shall Delta Dental be liable for duplication of services.
6. Delta Dental may decide a service is not necessary and appropriate under the terms of the contract even if your Dentist has furnished, prescribed, ordered, recommended or approved the service.
7. If you or any of your dependents have received compensation or free services by or through a public program, Delta Dental may reduce or coordinate benefits based on submitted documentation.
8. When an alternate benefit allowance is given, the procedure allowed is subject to the time limitations per tooth, as listed under Class II and Class III services.
9. When a procedure is benefited under a Class II or Class III service, then a new service is performed on the same tooth, it is subject to the time limitations of the prior service, therefore, benefits may be reduced on the new service.
10. Sterilization fees are not a billable expense by a participating Dentist.

Exclusions

1. Services for injuries or conditions which are compensable under Workman's Compensation or Employer's Liability Law, services which are provided to the covered person by any Federal or State Government Agency or are provided without cost to the covered person by any municipality, county or other political subdivision, or community agency.
2. A service or procedure that is not federally accepted as determined by Delta Dental Plan of Arizona or the American Dental Association.
3. A service or procedure that is not described as a benefit of this Contract.
4. A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
5. Dental and surgical services with respect to congenital or developmental malformations or cosmetic surgery or Dentistry for purely cosmetic reasons except in the case of newly born children covered from birth, or newly adopted children covered from date of adoption.
6. Inlay and veneer restorations are not a benefit. An alternate benefit allowance may be made.
7. Specialized techniques including but not limited to precious metal for removable appliances, precision attachments for partials or bridges, overdentures, overlays, implantology (procedures and appliances associated herewith) personalization and characterization.
8. Charges for any health care not specifically covered under this Contract including hospital charges, prescription drug charges, and laboratory charges or fees.
9. Charges for dental services which are started prior to the date the person became covered under this Contract.

If you are concerned that we have violated your private rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the Arizona Department of Insurance. The person listed below can provide you with the appropriate address upon request.

You may also file a complaint to the Secretary. In accordance with Federal Regulations (§160.306), your complaint must be filed in writing, either on paper or electronically. You must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable standards, requirements, and specifications. A complaint must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary for good cause. We will not retaliate against you for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints or desire additional information, please contact:

Customer Service – Privacy Officer
15648 North 35th Avenue
Phoenix, AZ 85053-3863

Phone: (602) 938-3131 or (800) 352-6132
Email: customerservice@deltadentalaz.com.

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- C. Crown build-ups are a benefit only when three or more of the five tooth surfaces are destroyed.
- D. Crown build-ups (pin, bonded, or post and core) is a benefit only once in a five-year period.
- E. Benefit shall not be made for these services when provided for children under 12 years of age. An allowance will be made for a preformed crown.
- F. Crowns are benefited on the date of preparation.
- G. Pre-formed crowns will be a benefit once in a five-year period for permanent teeth. This is considered a permanent crown.

CLASS IV: Orthodontic Benefits

Procedures using appliances (non-surgical) to treat poor alignment of teeth and/or jaws which significantly interfere with their function for adults and children. Benefit payments shall be distributed over the course of treatment as follows, or dictated by the Group Contract.

1. One-half of the pre-calculated maximum amount allowed will be paid upon insertion of the appliance/initial banding.
2. After six months from the date the appliances were placed, Delta Dental will make a payment for the balance of the pre-calculated maximum amount payable. (The patient must have current eligibility on this new date of service in order for this payment to be made.)

LIMITATIONS:

- A. Treatment must not begin prior to the patient's eighth birthday.
- B. Benefits are provided only if the first active appliance was inserted while the patient was covered for this benefit under this plan.
- C. Payments will be discontinued if treatment ceases for any reason.
- D. Repair or replacement of orthodontic appliance, for any reason, is not covered.
- E. If orthodontic work has been completed and benefited prior to the Delta Dental contract, and additional active treatment is required, a benefit with the Delta contract is allowable.
- F. For Transitional Care, refer to page 3 for details.

General Limitations - All Services

1. If an eligible person selects a service that is not provided for under the terms of the Contract or specialized techniques rather than standard services, Delta Dental will pay the applicable percentage of the allowable fee for the standard covered service and the patient is responsible for the remainder of the Dentist's fee.
2. Pre and post-operative procedures are considered part of any associated covered service. Benefit shall be limited to the covered amount for the covered services.
3. Local anesthesia is considered a component of any procedure in which it is used.
4. A temporary dental service will be considered an integral part of a complete

replacement of wholly extracted natural teeth with artificial teeth; onlays or crowns when teeth are severely decayed and severely fractured and cannot be restored by any other means; and partial denture, full denture, fixed bridge and crown repair.

Removable and Fixed Appliances

1. Bridges, partial dentures and full dentures for replacement of fully extracted or missing teeth for patients of 16 years or older.
LIMITATIONS:
 - A. Relines and rebases are a benefit once in a two-year period.
 - B. Bridges are benefited on the date of preparation.
 - C. Dentures and partials (including relines and rebasing) are benefited on the date of delivery.
2. Repairs and adding teeth to existing dentures, partial dentures or to a fixed bridge.
3. Temporary partial denture (replacement of any of the six upper or six lower front teeth, known as a flipper), but only if it is installed immediately following the loss of teeth (date of tooth extraction) and during the period of healing.
LIMITATIONS:
 - A. Temporary partial dentures are covered for individuals under 16 years of age.
 - B. Relines and rebasing of temporary removable partial dentures and full dentures are not covered.
4. Implants are not a benefit.
LIMITATION: In the event the treatment of choice by the doctor and patient is an implant, an alternate benefit of a full denture, removable partial denture, or pontic, whichever is less in cost, will be given. This alternate benefit is subject to the time limitation and guidelines of the procedure allowed.
5. Includes services to measure, fit, and adjust appliance up to three months after placement.
6. Prosthetics
LIMITATIONS:
 - A. Prosthetic services are limited to once in a five-year period, per tooth.
 - B. A fixed bridge and a removable partial denture are not benefits in the same arch.
 - C. Replacement of dentures and fixed bridges are limited to once in a five-year period.

Crowns and Onlays

Crowns and onlays as follows, but only when the teeth cannot be restored with fillings (described as a Class II Basic Benefit) due to severe decay or severe loss of hard tooth structure. There is no crown benefit allowed for teeth with hairline cracks or fractures.

- LIMITATIONS:
- A. Crowns and onlays are a benefit only once in a five-year period, per tooth.
 - B. Crowns and onlays are a benefit only when no other professionally acceptable form of treatment can be performed.

This Employee Dental Benefits Booklet should be read in conjunction with the Summary of Benefits. The Summary of Benefits included in this booklet is an outline of the benefits for your Employer Group Dental Contract with Delta Dental Plan of Arizona (DDPAZ). The benefits are subject to all provisions, terms and conditions of the Employer Group Dental Contract. For a more complete description of each benefit, please refer to the Table of Contents.

This Dental Benefits Booklet in conjunction with the Appeals Packet and the Employer Group Dental Contract and Master Application, issued to your Employer Group constitutes the complete document of insurance. This Dental Benefits Booklet, which describes the benefit provisions, takes the place of any other Dental Benefits Booklet issued to you on a prior date. Even if your dentist has furnished, prescribed, ordered, recommended or approved the service, it does not make it a dental or medical necessity or make the charge eligible for benefits even though it is not expressly excluded in the Delta Dental Plan of Arizona (DDPAZ) Benefits Booklet.

Eligibility

Eligible Member

You are covered under this program:

- A. While you are a full-time eligible member of the group; and
- B. If employed on or after the date this program first became effective (see Summary of Benefits); or
- C. On the first day of the month following completion of any eligibility waiting periods as specified in the Summary of Benefits; and
- D. When the required enrollment form information has been completed and forwarded by the group with the required periodic premium payments to Delta Dental Plan of Arizona.

A permanent full-time eligible member is one who works a required number of hours per week as stated in the Group Dental Contract.

Eligible Dependents

If you are enrolled for family coverage, the following dependents are covered under this program:

- A. Your lawful spouse;
- B. An unmarried dependent child under age 19, or if a full-time student in an accredited school enrolled in a minimum of 12 credit hours per enrollment period, benefits will continue up to the limiting age for students according to the Contract. The full-time student status must be maintained per enrollment period for benefits to continue. (Please refer to the Summary of Benefits for the student age limitation.) "Child" includes a natural child, step-child, legally adopted child (including a child placed with the Eligible Member for adoption), a foster child, and/or child(ren) to be covered by court order if residing with you and dependent on you for support.

Unmarried children over the age of 19 may continue to be eligible as dependents if they cannot support themselves because of physical handicap or mental incapacity that began before age 19, and are mostly dependent on you for their support and maintenance. Proof of incapacity must be provided to Delta Dental and your employer within 31-days of the request. Dependents in military service are not eligible.

Dependents are covered under this program:

- A. On the date the Member's coverage is effective; or
- B. On the date the dependent is acquired, meaning the birth, adoption, placement for foster care, placement for adoption with the insured and for whom the application and approval procedures for adoption have been completed, a marriage which results in stepchildren, and children required to be covered by court order, provided the enrollment form is submitted and premiums are paid within 31 days of becoming eligible. It is recommended that an enrollment form be submitted to Delta Dental for addition of newborn or any adopted children even if no

benefit within three years of their application.

Oral Surgery

Benefits will be provided for extractions and surgical procedures including pre-treatment and post-treatment care.

Periodontics

Benefits will be provided for treatment of diseases of the tissues supporting the teeth (gingiva and/or alveolar bone).

LIMITATIONS:

- A. Non-surgical periodontal treatment is limited to once in a two-year period.
- B. Surgical periodontal treatment is limited to once in a three-year period.
- C. Crown lengthening or single tooth gingivectomy is a procedure allowed once in conjunction with crown preparation, however, services cannot be performed on the same day as crown preparation.
- D. Guided tissue regeneration is not a benefit.

Endodontics

Benefits will be provided for necessary procedures for pulpal therapy on primary teeth (pulpotomy) and root canal treatment of infected tooth pulp (nerve) in permanent teeth.

LIMITATIONS:

- A. Endodontic benefits are limited to once in a three-year period for any tooth.
- B. Re-treatment is not a benefit unless it is demonstrated that unusual morphological or pathological conditions exist, and when performed by an endodontic specialist.
- C. Root canals are benefited on the date of completion, not including the final restoration.

Anesthesia

1. General anesthesia and intravenous sedation benefits will be provided when administered by a licensed Dentist in a dental office in conjunction with covered surgical procedures (excluding periodontal surgical services and endodontic therapy services).
2. Analgesia (nitrous oxide) is not a covered benefit.

Emergency Palliative Treatment

Emergency treatment for the relief of pain.

LIMITATION:

If the service is rendered with another covered service during the visit or if the palliative treatment is part of the final treatment, a separate benefit is not provided.

CLASS III: MAJOR BENEFITS

Prosthetics

Benefits are available for the following major dental services: initial placement or

1. Examinations or consultations twice in a benefit year.
2. One full-mouth x-ray (panorex, full-mouth, or seven single tooth x-rays) in a three year period.
3. Bitewing x-rays (x-rays of the crowns of the teeth) twice in a benefit year.
4. Single tooth x-rays as needed.
LIMITATION: Seven single tooth x-rays are considered one full-mouth x-ray.
5. Routine prophylaxis (scaling and polishing of teeth) twice in a benefit year.
LIMITATIONS: A. Routine prophylaxis is limited to twice in a benefit year, or one difficult prophylaxis may be exchanged for two routine prophylaxes. However, the difficult prophylaxis is limited to not more than once in a two year period.
B. A patient must have documented periodontal history (excluding a difficult prophylaxis), then routine prophylaxis and periodontal prophylaxis are considered to be interchangeable services.
6. Fluoride treatment for children up to the age of 18 years.
LIMITATION: Fluoride treatment is limited to not more than twice in a benefit year.
7. Space maintainers due to the premature loss of diseased posterior primary teeth up to the age of 14 years.
LIMITATION: Anterior space maintainers are not a covered benefit.

CLASS II: BASIC BENEFITS

Benefits are available for the following dental services to: (1) treat loss of hard tooth structure due to decay; (2) remove diseased or damaged teeth; (3) treat oral diseases of the supporting tissues (gingiva and/or alveolar bone).

Restorative

1. Fillings consisting of silver amalgam and synthetic tooth color (composite restoration) fillings.
LIMITATIONS: A. Benefit for silver amalgams are limited to one filling for each tooth surface in a two-year period.
B. Benefit for composite restorations are limited to one filling for each tooth surface in a three-year period.
2. Pre-formed crowns.
LIMITATION: Pre-formed crowns will be a benefit once in a two-year period for primary (baby) teeth.

Sealants

Sealants on unrestored permanent bicuspid and first and second molars.

- LIMITATIONS:
- A. Sealants are a benefit for eligible dependent children up to the age of 19 years.
 - B. Sealants are a benefit only on permanent bicuspid and molars with no decay or restorations.
 - C. Benefits are determined on a per tooth basis and not per surface.
 - D. Repair or replacement of sealants will not be a

additional premium is required, although it is not required. Coverage for newborn or adopted children or children placed for adoption includes necessary care or treatment of medically diagnosed congenital birth defects and birth abnormalities. For purposes of initial coverage, an adopted or placed for adoption child means a person under the age of 18 years.

Retiree and Disabled Member Eligibility and Termination

All State employees are covered under this program that have:

- A. Retired and are receiving income from a recognized retirement program of the State; or
- B. Opted upon retirement to enroll or continue enrollment in the group health Plan for active employees working for the State of Arizona; or
- C. Started receiving benefits from a long-term disability income insurance plan.

For retiree/disabled dependent eligibility, refer to Eligible dependents section on page 1.

If a retired member or an active member eligible for normal retirement dies which the surviving spouse's and/or dependent(s) health insurance is in force, the surviving spouse and/or dependent(s) is/are eligible for extended coverage by paying the group rate premium and any administrative expense charged by the State.

Coverage will terminate for a retiree/disabled member at the end of the month for which premiums have been paid. Dependents are terminated at the end of the month in which they lose eligibility. If a disabled member recovers from the disability and does not return to State service, their continuation in this plan is limited to 12 months.

Former Elected Officials Eligibility and Termination

A former elected official is one who:

- A. Has at least five-years of credited service in the elected officials' retirement plan; and
- B. Was covered under the ADOA group health plan at the time of leaving office; and
- C. Served as an elected official on or after January 1, 1983.

Application for enrollment must occur within 30 days of leaving office and is effective on the day after active coverage ceases or upon retirement.

For elected official's dependent eligibility, refer to Eligible dependents section on page 2.

Upon the death of a former elected official, the surviving spouse and eligible dependents can continue enrollment in the retiree health plan provided the deceased former elected official met the eligibility provisions and the surviving spouse makes application for coverage within 30-days of the death of the former elected official.

Upon the death of an elected official who is currently serving in the office, the surviving spouse and eligible dependents are eligible for coverage provided the deceased elected official met the eligibility provisions or would have met the eligibility provisions upon the completion of the term of office in which the deceased elected official was serving at the time of death, and provided the surviving spouse made an application for coverage within 30 days of the death of the elected official.

Dual Coverage

An individual cannot be eligible both as a member and a dependent under the same group plan. However, an individual may be covered as a member under one group plan and as a dependent under a different group plan (refer to the Coordination of Benefits section on page 14). If two eligible employees are husband and wife, only one of the eligible employees can cover their mutual dependents. In no instance, may both eligible employees cover their dependents.

Coverage for Late Enrollment

Members who do not enroll when first eligible, or during the open enrollment period, may join only if they incur a change in family status. Delta Dental will not require evidence of insurability for enrollment described here.

Effective Date of Coverage

If you have submitted a completed enrollment form to your Agency Insurance Liaison and authorized an applicable salary reduction by signing the form, your insurance will become effective on the 1st or 16th of the month, or the date of the family status event, provided the application is made within 31 days of the event.

Transitional Care

Transitional orthodontia dental care is covered when there is a change in dentists as a result of this Contract. The current dentist must provide Delta Dental with a pre-treatment program, number of months treatment is anticipated, amount already paid to the provider, and balance of billing. This transitional care will provide a no loss/no gain as a result of a change in dentist, even if the patient has already been banded for braces.

Termination of Insurance

Loss of Eligibility

Coverage for the Eligible Member and/or Eligible Dependent shall terminate on the 15th or last day of the month, based on the last day worked and period of premiums paid, or on the date of the family status event, in which:

- A. The individual ceases to meet the definition of eligibility above, or
- B. The required monthly premium is not received by Delta Dental from the Policyholder, or
- C. Full-time student status for over-age dependents is not maintained.

Coverage After Termination

Benefits shall not be paid for services provided after your coverage ends except for

4. The Dentist agrees to abide by Delta Dental's benefit determination and administration policies, and agrees to accept payment directly from Delta Dental.

Non-participating Dentist

If your Dentist is a Non-participating Dentist (a Dentist who has not signed an agreement with Delta Dental, or who has terminated as a Participating Dentist):

1. The member will be responsible for the submission of the claim form to Delta Dental for payment or pre-determination.
2. Delta Dental will pay the benefit payment directly to the member and the member will be responsible for the full amount of the billed charges by the Dentist.
3. The payment for the treatment will be based on the billed charges, or Delta Dental's NON-PARTICIPATING DENTIST FEE ALLOWANCE, whichever is less.

Out-of-State Dentist

If the Dentist you see outside Arizona is a member of that state's Delta Dental Plan, benefits will be based on Delta Dental Plan of Arizona's allowable fees. The patient is responsible for the difference in the billed charges and Delta's allowable fee. Claim forms are available from Delta Dental, your benefit administrator, or from a participating Dentist's office.

Outside The United States of America

If the Dentist you see is outside of the United States, benefits will be based on the billed charges, or Delta Dental Plan of Arizona's NON-PARTICIPATING DENTIST FEE ALLOWANCE, whichever is less. The patient is responsible for the full amount of the billed charges by the Dentist. The claim form must include the billed charges in that country's currency and a rate of conversion of the currency into United States dollars.

Description of Services

Only those services indicated as "Covered Benefits" on the Summary of Benefits are covered. Deductibles and maximum benefits are listed on the Summary of Benefits.

The program covers the following services when they are performed and completed by a licensed Dentist and when necessary and appropriate as determined by the standards of generally accepted dental practice. Services covered are subject to the Limitations and Exclusions described within this benefit booklet and in accordance with the group contract.

Covered Dental Services

CLASS I: ROUTINE BENEFITS

Diagnostic and Preventive Services

Benefits are available for the following services to diagnose or to prevent tooth decay and other forms of oral disease:

However, such newly acquired dependents will not be entitled to continue their insurance if items 1, 2, 3 or 4 listed in Section B of page 5, should subsequently occur.

How Does the Program Work?

Visit the dentist of your choice. If you do not have a dentist, select the one you wish and call either their office or Delta Dental Plan of Arizona to determine if they are a Participating Dentist with Delta Dental Plan of Arizona. A list of Participating Dentists is available from your member benefits office, or by calling Delta Dental. During your first appointment, advise your dentist that you are covered by Delta Dental Plan of Arizona under the Contract number indicated on the Summary of Benefits, and give the dentist your social security number. Dependents must use the member's social security number.

Pre-determination of Benefits

A pre-determination of benefits protects the patient from unanticipated charges. If your dentist determines that extensive services over \$250 are needed, ask your dentist to submit a claim form to Delta Dental with the proposed treatment identified. This permits Delta Dental to review the treatment plan for alternative treatment procedures which may be less costly, provided they do not affect the quality of care. The claim should be submitted to:

**Delta Dental Plan of Arizona
P.O. Box 43026
Phoenix, AZ 85080-3026**

Delta Dental will verify your eligibility and determine the amount of benefit to be paid by your Plan. A pre-determination Explanation of Benefits form will be returned to the dentist by Delta Dental. The amount of the allowable fee, the amount of benefit to be paid by Delta Dental, and the portion you are required to pay will be shown thereon, and you will know in advance what your financial responsibility for the treatment will be prior to the actual service being performed. The treatment plan should be discussed with the dentist before extensive treatment is begun.

Network of Dentists

Participating Dentist

If your dentist is a Participating Dentist (a dentist who has signed an agreement with Delta Dental):

1. The dental office will complete the claim form and submit it to Delta Dental for payment or pre-determination.
2. You are required to pay only your co-payment (if any) and/or deductible (if any) for covered benefits.
3. The Dentist has agreed to accept the total charges or Delta Dental's "allowable fee" for services rendered, whichever is less. Fees higher than the allowable fee will not be billed to the member.

multiple appointment procedures which were started while you were covered and were completed within 30 days from the date your coverage ended. Such benefits shall be subject to all conditions specified in the Contract.

Individual Conversion Provision

A covered person may enroll in an individual policy upon the death of a covered member, divorce, termination of employment or any condition except for failure of the Policyholder to pay the required premium.

Delta Dental requires all written applications and the first premium payment within 31 days for the policy to become effective. The effective date of the conversion policy shall be the day following termination under this Contract.

There will be no evidence of insurability requirement. The conversion policy may include covered dependent children for whom the spouse has responsibility for care and/or support.

The conversion policy is not available to a person covered by other dental benefits, which, together with this conversion coverage, would constitute duplicate insurance.

COBRA Continuation Required By Federal Law For You and Your Dependents

Every employer with 20 or more members that has a Member Dental Plan is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. If your group plan is subject to COBRA, you and your eligible dependents can elect to continue coverage in your dental program.

Federal law enables you and/or your dependents to continue dental coverage in the event that you lose coverage due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependents to continue dental coverage in the event that they lose coverage due to your death or entitlement to Medicare, divorce or legal separation, or with respect to a dependent child, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the Plan and is subject to Federal law, regulations and interpretations.

A. Members and Dependents Continuation Provision

If you and your dependents' coverage would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you and/or your dependents may continue coverage under this Plan upon payment of the required premium. You and/or your dependents must elect to continue coverage within 60 days from the latter of (1) the date the coverage would otherwise cease; or (2) the date Notice to the Right to Continue Coverage is sent. Such coverage will not be continued by the employer for you and/or your dependents, as applicable, beyond the earliest of the following dates:

1. Eighteen months from the date your work hours are reduced or your employment terminates, whichever occurs first;

2. The date all dental plans maintained by your employer terminate;
3. The date coverage ends due to your failure to make payment of the required premium in 45 days, then 30 days for subsequent payment;
4. The date of entitlement to Medicare;
5. The effective date of coverage under another group dental plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above; or
6. The date your dependent ceased to qualify as an eligible dependent.

B. Dependents Continuation Provision

If dental insurance for your dependents would otherwise cease because of:

1. Your death;
2. Your entitlement to Medicare;
3. Divorce or legal separation; or
4. With respect to a dependent child, failure to continue to qualify as a dependent,

Such coverage may be continued upon payment of the required premium to your employer. In the case of item 3 or 4 above, you and your dependent must notify your employer within 60 days of such event. In addition, a dependent must elect to continue coverage within 60 days from the latter of (a) the date the coverage would otherwise cease; or (b) the date Notice of the Right to Continue is sent.

The coverage of a dependent will not be continued beyond the earliest of the following dates:

1. Thirty-six months from the date of item 1, 2, 3 or 4 above, whichever occurs first;
2. The date coverage ends due to failure to make payment of the required premium in a timely manner;
3. The date all dental plans maintained by your employer terminate; or
4. The date the dependent becomes covered under another group dental plan, unless the dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

If coverage for your dependent was continued under Section A and he/she becomes eligible for continuation under Section B, the period of time for which coverage was continued under Section A will be deducted from the 36 months available under Section B.

If your dependent would lose coverage because you are not eligible to elect or continue COBRA because you are entitled to Medicare, your dependent may continue coverage for up to 36 months from the date you became entitled to Medicare. Your dependent COBRA period is calculated from your date of entitlement regardless of whether you became entitled to Medicare before,

simultaneously with, or after the date of your loss of employment or reduction in work hours. In either case, the available coverage would not be more than 36 months. Any coverage provided under the COBRA plan would be applied to the 36-month total.

C. Disabled Individuals Continuation Provision

If you or your dependent is disabled on the date of termination of employment or reduction in work hours, you may continue dental insurance for up to an additional 11 months beyond the 18-month period. To be eligible you or your dependent must:

1. Be declared disabled under Title II or XVI by the Social Security Administration; and
2. Notify the Plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan administrator with a copy of the determination.

Termination of coverage during the 29-month period will occur if you or your dependent is found by the Social Security Administration to be no longer disabled. Termination will occur on the first day of the month beginning more than 30 days after the date of the final determination. All reasons for termination which apply to the initial 18 months will also apply for any additional months of coverage.

D. Services and Benefits Under Continuation Coverage

If you or your dependents fail to choose or pay for continuation coverage as required, you and your dependents shall be responsible for repayment on a fee-for-services basis of all charges for services and benefits provided under this Plan after the termination date.

E. Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both items 1 and 2 below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of:

1. The continuation required by Federal law; or
2. Any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If while your insurance is being continued under the continuation required by Federal law provisions you acquire a new dependent, such dependent will be eligible for this continuation provided:

1. The required premium is paid; and
2. Delta Dental is notified of your newly acquired dependent in accordance with the terms of the policy.